STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 01 B. WING	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA RD FORT WAYNE, IN 46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/08/12 and 11/09/12 Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Byron Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This four story facility with a	K0000	This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors have been installed in all resident rooms. The facility has a capacity of 191 and had a census of 111 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage and found in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered, except the Friendship Corner elevator vestibule. Areas providing facility services which were not sprinklered were the 4 elevator equipment rooms, the lower level generator room, the biohazard storage room, 1 elevator storage room and the old pharmacy sump pump room. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/19/12.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 1 of 1 restroom corridor doors in Section 1 closed and latched into the door frame. This deficient practice was not in a resident care area but could affect any number of staff. Finding include: Based on observation with the Director of Plant Operations on 11/09/12 at 11:36 a.m., the corridor door to the Section 1 restroom lacked latching hardware and did not latch into the door frame. Section 1 is currently closed and the restroom is being	K0018	**K018 NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** 1) Latching hardware was installed on the door. This area is not inhabited by residents and access to the area is very limited with staff as well. 2) All furniture, beds, wheelchairs, and general storage items have been removed from the room corridor exits. This area is not inhabited by residents and access to the area is very limited with staff as well. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** 1) No resident has the	12/09/2012

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	used for storage of over the bed tables. This was acknowledged by the Director of Plant Operations at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 9 of 12 resident room corridor doors in Section 1. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on observations with the Director of Plant Operations on 11/09/12 at 11:17 a.m., the corridor doors to nine of the twelve resident rooms in Section 1 were obstructed by furniture, beds, wheelchairs and general storage preventing the doors from closing and latching into the door frame. Section 1 is currently closed and the resident rooms are being used for storage. This was acknowledged by the Director of Plant Operations at the time of observations.		potential to be affected by the practice. This area is closed to resident, guests, and visitors. 2) No resident has the potential to be affected by the practice. This area is closed to resident, guests, and visitors. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** 1) The latch has been changed and therefore will not recur. 2) All maintenance staff will be in-serviced as to the proper way to store items in the closed unit to ensure general storage items do not block the corridor exits. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The Director of Plant Operations, or his designee, will monitor the closed unit monthly for items that might have been placed in corridor exit paths. Please see attachment #1. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months. **By what date the systemic changes will be completed.** December 9, 2012	

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	3.1-19(b)			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 trash collection/biohazard storage rooms was provided with a self closing device. This deficient practice could affect five first floor residents. Findings include: Based on observation with the Director of Plant Operations on 11/09/12 at 10:49 a.m., a self closing device was not provided on the corridor door to the room labeled waste/pump room with three trash barrels and one biohazard barrel used for the collection of trash and biohazardous waste. This was	K0029	**K 029 NFPA 101 Life Safety Code Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A self-closing device was installed on the corridor door to the room labeled waste/pump room. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the door not having a self-closing device. **What measures will be put into place or what systemic changes will be made to ensure that the**	12/09/2012

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	acknowledged by the Director of Plant Operations at the time of observation. 3.1-19(b)		**deficient practice does not recur.** The systemic change was that the self-closing device has been installed and will remain on the door. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The Director of Plant Operations, or his designee, will monitor the self -closing device monthly to ensure proper functioning of the device. Please see attachment #2. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months. **By what date the systemic changes will be completed.** December 9, 2012	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 2 of 18 corridors were maintained to provide adequate headroom. LSC 7.1.5 requires the means of egress shall be designed and maintained to provide adequate headroom as provided in other sections of this Code and shall not be less than 7 feet 6 inches with projections from the ceiling not less than 6 feet 8 inches nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 feet 8 inches. This deficient practice could affect any residents, staff and visitors in the facility using these two basement corridors. Findings include: Based on observations on 11/08/12 from 12:20 p.m. to	K0038	**K 038 NFPA 101 Life Safety Code Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The cited corridors are not corridors resident are required to use and are not part of corridors for egress from the building. This facility has been granted a waiver for many years and we will once again request the waiver. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** The ceiling heights have been this ways for decades and no resident has been adversely affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The ceiling area cited is in the basement area and was built in the 1920's There is no economically	12/09/2012

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	1:33 p.m. and 11/09/12 from 10:20 a.m. to 2:00 p.m. with the Director of Plant Operations, the following areas in the basement failed to provide adequate headroom: a. The basement ceiling height in the east-west corridor measured six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along the 70 foot corridor that measured five feet seven inches from the floor. This was acknowledged by the Director of Plant Operations at the time of observations. b. The ceiling height at the south basement corridor smoke barrier wall measured five feet nine inches. Additionally, there was a pipe protruding below the ceiling which ran along the center basement corridor that measured six feet from the floor and the north-south corridor intersection had pipes protruding below the ceiling which ran along the corridor that measure five feet nine inches from the floor. This was acknowledged by the Director of Plant Operations at the time of observations.		feasible way to raise the ceiling height. The useful life of the building is only 3 -5 years. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** We will be requesting a waiver. Please see attachment #3. **By what date the systemic changes will be completed.** December 9, 2012	

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	3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 4 of 4 elevator equipment rooms, 1 of 2 storage room, 1 of 2 generator rooms, 1 of 1 old pharmacy sump pump rooms and 1 of 1 Friendship Corner elevator vestibule areas in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect staff with the exception of the Friendship Corner lounge with a capacity of twenty residents.	K0056	**K 056 NFPA 101 Life Safety Code Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Bids have been obtained and signed. The work has been scheduled and the sprinkler systems will be installed. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the lack of sprinklers in the identified areas.	12/09/2012

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	Findings include: Based on observations with the Director of Plant Operations on 11/08/18 from 12:20 p.m. to 1:33 p.m. and 11/09/12 at 11:16 p.m., the following areas lacked sprinkler coverage. a. Lower level elevator # 4 equipment room and storage room b. Lower level elevator equipment room for the freight elevator c. Lower level elevator # 6 equipment room d. Lower level generator/boiler room e. Lower level biohazard storage room f. First floor old pharmacy sump pump room g. Pent house elevator equipment room h. Friendship Corner elevator vestibule area Based on an interview with the Director of Plant Operations at the time of observations, he was aware of this requirement and has contacted a sprinkler company for an estimate. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** A bid has been obtained for installing sprinklers in the cited areas. The work will be scheduled and completed as quickly as the contractor can accomplish the work needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** Once the sprinkler systems are installed, the corrective action has been completed. It will then become part of system wide sprinkler testing program conducted by an outside vendor as required by law. Please see attachment #4 **By what date the systemic changes will be completed.** December 9, 2012	

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	3.1-19(ff)			

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 3 of 3 areas used for transferring of oxygen were separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 22 residents. Findings include: Based on an observation with the Director of Plant Operations on 11/08/12 at 1:33 p.m. and on 11/09/12 at 11:02 p.m. and then	K0143	**K 143 NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A bid has been obtain to purchase new doors for the three areas identified. The installation of the doors will depend on the delivery date of the doors to the vendor. Please see attachment #5. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic**	12/09/2012

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	again at 1:07 p.m., the first, second and third floor oxygen storage/transfilling rooms had an unrated metal door. Each room contained one or more large liquid oxygen cylinders. Based on an interview with the Director of Plant Operations at the time of observations, he was unable to verify the fire rating of the door to the oxygen storage/transfilling rooms. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur.** Once the doors have been replaced, the systemic change will be completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** Once the doors have been replaced, there will be a permanent solution to the issue and monitoring will not need to take place. **By what date the systemic changes will be completed.** December 9, 2012	

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect staff. Findings include: Based on an observation with the Director of Plant Operations on 11/09/12 between 11:09 a.m. and 12:07 p.m., a regular light weight extension cord was plugged in to another light weight extension cord and providing power for the pencil sharpener in the Nursing Supervisor's office and a regular	K0147	**K 147 NFPA 101 Life Safety Code Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** 1) The extension cords have been removed from the Nurse Supervisor Office. 2) The heavy weight extension cord has been removed and replaced with conduit in the maintenance workshop. **How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by these deficient practices. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** 1) The pencil sharpener was relocated closer to an outlet so an extension cord is no longer needed.	12/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING 01 B. WING	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	heavy weight extension cord was providing power for a computer in the maintenance workshop. This was acknowledged by the Director of Plant Operations at the time of observations. 3.1-19(b)		2) A permanent power source has been added to the maintenance workshop to an extension cord will no longer be needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The Director of Plant Operations, or his designee, will monitor the building for improper use of extension cords. Please see attachment #6. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months. **By what date the systemic changes will be completed.** December 9, 2012	